Granville HEALTH SYSTEM
Quality Care...Close To Home

Granville Health System, Physician Practices

Patient Registration/Consent Form

Patient Centered Medical Home

PREFERRED PHARMACY INFORMATION

(Please print clearly, all information requested below)

PHARMACY: | Phone Number:

PATIENT INFORMATION

Last Name | First | MI

Address 1:

Address 2:

City: | State:

Zip Code:

(PCP) Primary Care Provider/Physician:

PHONE CONTACTS

Home # | Work # | Cell #

SSN: | Sex: ☐ Male ☐ Female | Birth Date:

Marital: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Employment: ☐ Full Time ☐ Part Time ☐ Self ☐ Not ☐ Retired ☐ Military

Preferred E-Mail:

Name of Practice/Office/Group: | Phone #:

Race:
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Black/African ☐ American Indian/Alaska native ☐ White
☐ More than one race

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Choose not to report

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred method of contact with you: ☐ Phone ☐ E-Mail ☐ My Health Electronic Portal

Learning Preference: ☐ Visual ☐ Voice ☐ Read

Dominant hand: ☐ Right ☐ Left ☐ Both

INSURANCE INFORMATION

(Please Provide Your Insurance Card to the Receptionist for Copying)

I have ☐ PRIMARY Insurance ☐ SECONDARY Insurance

I ☐ Have my insurance card(s) today
I ☐ DO NOT have my insurance card(s) today

☐ I DO NOT have insurance and understand that a SELF-PAY pre-payment may be required

I am ☐ insured by a policy in my name (I am Subscriber)
I am ☐ insured by a policy in someone else's name (I'm NOT Subscriber)

Subscribers name on card (If other than you) | Subscriber Date of Birth:

Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other

WORKER'S COMPENSATION CLAIM INFORMATION

Employer (Company) Name: | Supervisor: | Phone Number:

Claim #: | Workers Comp. Insurance Carrier: | Date of injury:

EMERGENCY CONTACTS

(Local friend or relative not living at same address)

1st Emergency Contact:	Relationship to Patient:	Address:	Home Phone #:	Cell or Work #:
2nd Emergency Contact:	Relationship to Patient:	Address:	Home Phone #:	Cell or Work #:

The information provided by me above, is true and accurate to the best of my knowledge. I hereby authorize the Medical Provider(s) and/or staff member(s) of Granville Health System's Outpatient Practices to administer any treatment, medical or surgical, considered necessary or advisable, to diagnose and/or treat my condition(s). The diagnostic/treatment process may require/include radiological and/or laboratory testing, administration of local anesthesia and/or the administration of medications. I authorize the release of my personal health information to my active insurance carrier(s) for the sole purpose of determining payment by said carrier(s) for covered services rendered by Granville Health System. I authorize and request payment by my insurance carrier, on my behalf, to Granville Health System, for any/all covered services provided to me. I also fully understand and assume full responsibility for any unpaid balances due for services provided me. In addition, I authorize Granville Health System, pursuant to its agreement with Granville Health Inc., to apply any refundable charges to outstanding patient accounts with either Granville Health System or Granville Health Inc., for which I have accepted responsibility as guarantor. I acknowledge that I have reviewed and understand the Health Information Portability and Accountability Act (HIPAA) Notice of Privacy Practices. I hereby provide Granville Health System permission to use my mobile phone number to communicate with me regarding my treatment, services rendered and or scheduling by live or recorded means. By providing Emergency Contact information, you are giving authorizing Granville Health System staff to notify the contact and advise them of your location only unless you directed otherwise. Granville Physician Practices WILL NOT disclose or share any of your personal medical information without your separate consent.

_____ _____

Patient / Guardian Signature *Today's Date*

Granville Gastroenterology Associates
103 C Professional Park Dr.
Oxford, NC 27565

Patient Information:

Patient Name: _____ DOB: _____
Primary Care Provider: _____
Phone Number _____
Could you be pregnant? ☐ YES/How many months?____ ☐ NO
Do you have a living will? ☐ YES ☐ NO
Do you have any metal implants? ☐ YES/ Where? _____ ☐ NO
Have you had a flu vaccination? ☐ YES ☐ NO

Medical History:

___ AIDS
___ Allergic rhinitis
___ Alcoholism
___ Asthma
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Bleeding disorder
___ Breast lumps
___ Bronchitis
___ Cancer: _____
___ Thyroid Disease
___ COPD
___ Cataracts
___ Chemical Dependency
___ Depression
___ Diabetes
___ Earache
___ Emphysema
___ Fibromyalgia
___ Glaucoma
___ Gout
___ GERD
___ Hearing loss
___ Renal failure
___ Heart disease
___ Hepatitis
___ Hernia
___ High Cholesterol
___ High blood pressure
___ HIV
___ Kidney stones/disease
___ Leg ulcers
___ Liver disease
___ Heart murmur
___ Migraines
___ Multiple sclerosis
___ Stomach ulcers
___ Pacemaker/Defibrillator
___ Liver disease
___ Pneumonia
___ Prostate problems
___ Seizures
___ Sinus disease
___ Sleep Apnea
___ Strep throat
___ Stroke
___ Transfusion
___ Tuberculosis
___ Psychiatric Care
___ Sickle Cell Anemia

Other: _____

Allergies/Contraindications:

_____
_____

Family History: (Please check all that apply to your family members):

	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Allergies						
Asthma						
Bleeding disorder						
Cancer						
Cystic fibrosis						
Diabetes						
Heart disease						
High blood pressure						
Sinus disease						
Stroke						

Other: _____

SOCIAL HISTORY:

Please describe your current tobacco use:

☐Smoker, current status unknown ☐Light tobacco smoker ☐Heavy tobacco smoker ☐Current every day smoker
☐Current some day smoker ☐Former smoker ☐Never smoker ☐Unknown if ever smoked

Do you drink alcoholic beverages? ☐Yes ☐No

Have you ever used any illicit drugs? ☐Yes ☐No

Review of symptoms: (Check the symptoms you are having related to today's visit)

General: ☐**Normal**
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Nausea
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

MEN ONLY: ☐**Normal**
- ☐ Erection Difficulty
- ☐ Penis Discharge
- ☐ Testicle Lumps
- ☐ Testicular Pain

Psychiatric: ☐**Normal**
- ☐ Depression
- ☐ Schizophrenia
- ☐ Suicide Attempt

Urinary: ☐**Normal**
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Pain/Burning on Urination
- ☐ Urine Leakage

Skin: ☐**Normal**
- ☐ Change in Moles
- ☐ Dryer Skin
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching/Rash
- ☐ Non-healing sores

Respiratory: ☐**Normal**
- ☐ Chronic Cough
- ☐ Excessive Sleepiness
- ☐ Spitting Up Blood
- ☐ Snoring
- ☐ Wake up Feeling Unrested
- ☐ Wheezing

Cardiovascular: ☐**Normal**
- ☐ Chest Pain
- ☐ Murmur
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Ankles

GI: ☐**Normal**
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Change in Bowels
- ☐ Changes in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Nausea or Vomiting
- ☐ Vomiting Blood
- ☐ Rectal Bleeding
- ☐

Allergy: ☐**Normal**
- ☐ Hay Fever
- ☐ Immunosuppressive Drugs
- ☐ Immune Therapy

HEENT: ☐**Normal**
- ☐ Bleeding Gums
- ☐ Choking Sensation
- ☐ Clouded Vision
- ☐ Difficulty Swallowing
- ☐ Dizziness/Vertigo
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Lumps in Neck
- ☐ Mouth Sores
- ☐ Nose Bleeds
- ☐ Oral Ulcers
- ☐ Painful Swallowing
- ☐ Reflux
- ☐ Ringing in the Ears
- ☐ Sinus Congestion
- ☐ Snoring
- ☐ Sore Throat
- ☐ Vertigo
- ☐ Vision Changes

WOMEN ONLY: ☐**Normal**
- ☐ Abnormal PAP
- ☐ Bleeding between Periods
- ☐ Breast Mass
- ☐ Extreme Menstrual Pain
- ☐ Irregular Periods
- ☐ Vaginal Discharge

Endocrine: ☐**Normal**
- ☐ Hand Size Changes
- ☐ Heat/Cold Intolerant
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Shoe Size Changes

Neurological: ☐**Normal**
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Memory Loss
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Weakness

Musculoskeletal: ☐**Normal**
- ☐ Back Pain
- ☐ Muscle Weakness
- ☐ Joint Pain
- ☐ Joint Swelling

Childhood Diseases:
- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever

Surgical History:

DATE:

Medications: Did you bring a list of your medications? If yes, please give to nurse. If no, please fill out below.

Please List Physicians who are currently seeing or have seen in the last year

PEDIATRIC PATIENTS ONLY:

Was your child born premature? ☐Yes ☐No if yes, how many weeks? _____

What was your child's birth weight? _____

Has your child ever needed as breathing tube or ventilator? ☐Yes ☐No

Does your child use an Apnea monitor? ☐Yes ☐No

Are your child's vaccinations up to date? ☐Yes ☐No

Does your child have any congenital health problems? ☐Yes ☐No

Did your child have any problems during delivery? (Please list)

_____

_____

WOMEN ONLY:

Date of Last Menstrual Period _____

Age menstrual periods started _____

Do you still have regular periods? ☐Yes ☐No

If no, how old were you when they stopped? _____

How many times have you been pregnant? _____

How many children do you have? _____

Do you or did you ever take birth control pills? ☐Yes ☐No

If so, for how long? _____

Do you, or did you ever, take hormone replacement? ☐Yes ☐No

If so, for how long? _____

Date of last Pelvic exam _____

Date of last Mammogram _____

Do you perform a self-breast exam? ☐Yes ☐No

Menstrual problems? Please describe below

_____

_____

_____

Nursing Assistant: BP: ____/____ Weight (kg):_____ Height (in):_____ Pulse:_____ Temp:_____ Resp:_____

Pain: 0 1 2 3 4 5 6 7 8 9 10

Granville Gastroenterology Associates
103 Professional Park Drive, Suite C
Oxford, North Carolina 27565

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Medical Record # _____ Date of Birth: _____

☐ I authorize _____ to **RELEASE** information for patient care to

☐Dr. Albin Abraham, Granville Gastroenterology Associates to the address listed above.

☐ I authorize _____ to **OBTAIN** information for patient Care from:

☐Dr. Albin Abraham, Granville Gastroenterology Associates to the address listed above.

The specific information includes the following dates of service: _____

PURPOSE OF THIS RELEASE: *(Check appropriate boxes and Include other information where Indicated.)*
☐ Continued Medical Care ☐ Legal ☐ Insurance ☐ Personal Use

INFORMATION TO BE RELEASED/OBTAINED *(Check appropriate boxes and Include other information where Indicated.)*
☐ Comprehensive Record ☐ Laboratory Results ☐ Office Visit Note
☐ Immunization Records ☐ Radiology Reports ☐ Operative Report/Procedure Note
☐ All ☐ Other: _____

I hereby authorize the use and/or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. NO individual has coerced me into signing this authorization, and I am providing this authorization under my own free will. I understand that once this information is received by the authorized organization or person, then it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I understand that the person(s) or organization(s) authorized to make the requested use and/or disclosure may not condition treatment, payment, enrollment or eligibility for benefits, on my executing this authorization.

I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that the person(s) or organization(s) authorized to make the requested use and/or disclosure have taken action in reliance of this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. This authorization will expire on the following date: _____.

_____ _____
Patient Signature Date:

Attachment: (1) GHI Specialist Practices Cancellation and No-Show Policy Statement

GHI SPECIALIST PRACTICES CANCELLATION AND NO SHOW POLICY STATEMENT

- We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that time-slot to other patients.

- Office appointments which are cancelled with less than 24 hours notification and patient "no-shows", may be subject to the following cancellation fee schedule:
  - First missed office appointment:
    - ❖ No charge as courtesy.
  - Second missed office appointment:
    - ❖ $25 fee will be billed to the patient's account.
  - Third and subsequent missed office appointment:
    - ❖ $50 fee will be billed to the patient's account.

- Procedure cancellations require 3-business day advance notice. Procedure cancellations with less than 3 days' notice and all procedure "no shows" may be subject to a $75.00 cancellation fee.

- The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

- We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Patient's requests for waivers of fees may be submitted to the Director, Physician Practices for review and consideration.

- Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Clinic Coordinator at (919) 690-3499.

Please sign that you have read understand and agree to this Cancellation and No show Policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

Medicare Secondary Payer Development

Name: _____ Medicare I.D. # _____ Date of Birth: _____

PART 1

1. Do you receive Black Lung benefits? ☐ Yes ☐ No Date began: _____
   Black Lung is primary for claims related to Black Lung only? ☐ Yes ☐ No
2. Do you receive VA benefits? ☐ Yes ☐ No
3. Is this related to: ☐ Work ☐ Accident (Auto) ☐ Third Party Liability

Insurance Name: _____
Address: _____
_____
Name of Insured: _____
I.D. #: _____

If Workman's Compensation, Employer: _____

PART 2

1. Is your Medicare primary? ☐ Yes ☐ No
2. Is Medicare based on: ☐ Age ☐ Disability ☐ End Stage Renal Disease

AGE/DISABILITY:

1. Are you or your spouse working? ☐ Yes ☐ No
   If yes, are you: ☐ Full Time ☐ Part Time If no, date of retirement: _____

Employer: _____ Number of Employees: _____
Insurance: _____
Address: _____
_____

Policy Holder: _____ Date of Birth *(Policy Holder)* _____
I.D. # _____ Group #: _____

END STAGE RENAL DISEASE:

1. How long have you had End Stage Renal Disease?: _____

Are you in 30 month coordination period? ☐ Yes ☐ No

Do you have Group Coverage: ☐ Yes ☐ No
Insurance: _____
Address: _____

I.D. # _____

Signature: _____ Date: _____

Revised 02/03